Open Enrollment for Participating Group Employees: May 8 - 26, 2017
Frequently Asked Questions (FAQs)

Please note:

- **This document was last updated on April 20, 2017. Please continue to check back for updates.**
- **Please read the "Important Background Information" document before viewing these FAQs**

Table of Contents

Pre-Open Enrollment To-Do's

(1) What should benefit-eligible employees do before Open Enrollment to ensure they are ready?

Participating Group employees should provide their HR Office with any changes to their personal information- home address, phone number and email address. Your Personal Contact Information is used to provide you with important information related to Open Enrollment and for the benefit plans you select for you and your family, this information will be shared with those vendors so that they may provide you with ID Cards and Welcome Kits and outreach to you as appropriate regarding important care management programs and services.

Return to Table of Contents

New Features

(2) Why are the Highmark IPA/HMO and Highmark CDH Gold Plans no longer available as of July 1, 2017?

In December 2016, the SEBC approved the contract awards for the medical (health plan) third party administrators (TPAs) to serve the GHIP, effective July 1, 2017: Aetna to administer the Consumer Directed Health Plan (CDH) and HMO Plan; and Highmark Delaware to administer the First State Basic PPO Plan, Comprehensive PPO Plan, and Special Medicfill Medicare Supplement Plan (available only to Medicare pensioners). The recommendation for contract awards was the culmination of well over seven months of planning, education and discussion. Currently, employees and non-Medicare pensioners have six plans to choose from; however, there are two HMO and two CDH Gold plans with nearly identical plan designs and premiums. Decreasing the plan offerings from two HMO and CDH plans to one CDH and HMO plan allows for an easier decision making process for eligible members and increases administrative efficiency.

(3) How favorable is the provider network for the Aetna and Highmark Delaware plans?

Overall network access (i.e., access to any provider) is favorable in the areas where employees and pensioners reside. Across the State of Delaware Group Health Insurance Program (GHIP) entire population – 97.2% of in-network patients remain in Aetna's physician network; 99.6% in Aetna's facility network. This compares to Highmark at 99.9% and 100.0% respectively. In terms of key providers – PCPs, OB/GYNs, pediatricians & other specialists – desired access was 99.9%

Specific to providers providing primary care services – PCP, family & general practice, OB/GYN, internal medicine, pediatric & geriatric medicine* (*direct access but not one where members can select as a PCP)

- Aetna network access is more than sufficient in all areas with providers who are accepting patients and/or taking patients with other insurance
- Disruption of current Highmark HMO membership for physicians in these categories is less than 2.0%. Aetna continues to actively outreach to providers not currently in their network who were identified as having more than 25 Highmark HMO and/or CDH Gold members.

(4) What will happen to members currently enrolled in the Highmark IPA/HMO Plan and Highmark CDH Gold Plan, since they are no longer available as of July 1, 2017?

The IPA/HMO Plan and CDH Gold Plan offered through Highmark Delaware will no longer be available effective July 1, 2017; therefore, these plans will not be available for selection during Open Enrollment. Participating Group employees currently enrolled in either plan will be automatically defaulted into the Aetna equivalent plan, if no action is taken during Open Enrollment. Please see Question #6 about the importance of selecting a PCP for the Aetna HMO Plan.

(5) I am currently in the Highmark CDH Gold Plan and noticed that my ID card has PPO on it. Will I need to make a new health plan selection or be defaulted into the Aetna CDH plan?
Yes, employees who are enrolled in the Highmark IPA/HMO or CDH Gold Plan in the current plan year and take no action during Open Enrollment will have coverage in the corresponding Aetna HMO or CDH Plan for the plan year that begins July 1, 2017.

(6) What will happen to employees currently enrolled in the Highmark CDH Gold Plan who have unused HRA funds at the end of the plan year?
If you enroll in the Aetna CDH Gold plan effective July 1, 2017, and you were enrolled in either the Highmark or Aetna CDH Gold Plan through June 30, 2017, any unused HRA funds will rollover to the new plan year.

(7) What will happen if an employee is currently enrolled in the Highmark IPA/HMO or CDH Plan and chooses not to actively participate in Open Enrollment? Will they still be enrolled in a health plan for the plan year that begins on July 1, 2017?
Employees who are enrolled in the Highmark IPA/HMO or CDH Gold Plan in the current plan year and take no action during Open Enrollment will have coverage in the corresponding Aetna HMO or CDH Plan for the plan year that begins July 1, 2017. Their coverage will not be terminated if they take no action during Open Enrollment; however, these employees will lose the opportunity to consider other plans until the next Open Enrollment unless they experience a qualifying event during the plan year. Please see Question #6 about the importance of selecting a PCP for the Aetna HMO Plan.

(8) Do employees need to actively select a Primary Care Provider (PCP) if they are currently a Highmark IPA/HMO member and automatically default into the Aetna HMO plan?
Employees currently enrolled in a Highmark IPA/HMO plan who automatically default into the Aetna HMO plan at the start of Open Enrollment and do not select a PCP during Open Enrollment under the Aetna HMO plan, will have one automatically assigned to them by Aetna (based on location/proximity of the member to the provider's office). This is in part because Highmark and Aetna use different provider codes which systematically does not allow for a transfer of PCP information from one vendor to another.

Employees defaulting or enrolling in the Aetna HMO Plan are encouraged to use Aetna's DocFind during Open Enrollment to locate a PCP they want and select their chosen provider.

DocFind Instructions:

1. Visit Aetna's DocFind.
2. Under Geographic Information, select **Zip code**, **City** or **County**.
    a. If using Zip code – Please provide 5 digit zip code and select distance/radius.
    b. If using City – Please provide City and State.
    c. If using County – Please provide County and State.
3. Under Provider Category, select **Medical Providers**.
4. Under Provider Type, select **Primary Care Physicians**.
5. Under Plan, select plan choice - either the **HMO** or **Aetna CDH Gold Plan**.

6. You can narrow your search by specialty, provider's name and other options by choosing the **More Options** button.
7. Click the **Start Search** button.
8. View your search results.
   *Note: For the Aetna HMO Plan, the Primary Office # (Example - **Primary Office# 000000**) found in DocFind under your chosen provider is the Physician's ID Number.*

After Open Enrollment closes, employees wanting to change their Aetna PCP will need to contact Aetna directly at 1-877-542-3862.

(9) What consumerism resources will be available prior to and during Open Enrollment to help employees make informed decisions?
During the week of April 3, SBO launched a curriculum of online mini-videos (5-10 minutes each) to educate employees and pensioners on What's New for Open Enrollment, the health plans offerings and the Coordination of Benefits policy. During the week of April 24, SBO launched an online, Interactive Open Enrollment Benefits Guide which replaces the standard, static Open Enrollment PDF Booklet. Employees and pensioners are able to drive the user experience. The Interactive Open Enrollment Benefits Guide uses audio and screen interaction with employees and pensioners to help them learn about available benefits including navigation demos of the SBO website. SBO encourages benefit-eligible employees to use these consumerism resources (i.e., online mini-videos, Interactive Open Enrollment Benefits Guide, etc.) prior to and during Open Enrollment, as a way to assist them in being a wise health care consumer when selecting the benefit plans that best meet their needs and the needs of their family.

(10) Where do I go to access and learn more about the mini-videos?
Visit de.gov/statewidebenefits (Select the "Open Enrollment" button, then choose the button for "Participating Groups"). Under Consumerism Resources, select the link for "Curriculum of Informational Mini-Videos."

Plan Changes And Rates

(11) Are there changes to the 2017 benefit plan design and rates?
On March 6, 2017, the State Employee Benefits Committee (SEBC) voted to make no changes to the rates or plan designs of the health plans available to State of Delaware employees and non-Medicare pensioners for the plan year that begins on July 1, 2017. The SEBC will revisit as needed, changes to the Group Health Insurance Program (GHIP) health plans and rates based on Governor Carney's Budget Reset.

(12) Where can I go to view a side-by-side comparison of the health plan options available to me and my family for the plan year that begins on July 1, 2017?
A Health Plan Comparison Chart is available online at de.gov/statewidebenefits (Select the "Open Enrollment" button, then choose the button for "Participating Groups"). Under Consumerism Resources, select the link for "Health Plan Comparison Chart."

(13) I heard that Governor Carney's FY18 Budget Proposal recommends increasing member cost share for health plan coverage, as well as eliminating the double state share benefit. Do these recommendations impact this May's Open Enrollment and my coverage for the plan year that begins July 1, 2017?

Governor Carney's budget proposal released on March 23, 2017 includes recommendations to adjust the cost share in employee health plans and to eliminate double state share. These recommendations would require legislation that must be passed by the General Assembly and signed into law by the Governor; therefore, these recommendations are **not** part of the changes outlined in this May's Open Enrollment for the plan year that begins July 1, 2017. If legislation is introduced and passed that adjusts cost share or eliminates double state share, a separate "Special Enrollment" opportunity will be communicated and made available to any impacted employees and pensioners at least 60 days in advance of the effective date of the changes to allow them the chance to make changes to their current benefit elections or to drop coverage if they wish to do so.

Enrollment

(14) When is Open Enrollment?

The Open Enrollment period for Participating Group employees is May 8 - 26, 2017.

(15) Do all employees have to complete Open Enrollment this year, regardless of whether they are making any changes?

Benefit-eligible Participating Group employees are encouraged to actively participate in Open Enrollment by reviewing their benefits coverage and taking advantage of this once a year opportunity to make benefit changes and/or elections.

The IPA/HMO Plan and CDH Gold Plan offered through Highmark Delaware will no longer be available effective July 1, 2017; therefore, these will not be available for selection during Open Enrollment. Participating Group employees currently enrolled in either plan will be automatically defaulted into the Aetna equivalent plan, if no action is taken during Open Enrollment.

State medical (health) and dental plan enrollment for the current plan year will continue or carry over into the new plan year which begins on July 1, 2017 if the employee does not make a change to their elections. Employees currently enrolled in the Highmark IPA/HMO and Highmark CDH plans (which will be discontinued after June 30, 2017) who do not make changes will be defaulted into the same plan type and tier offered by Aetna.

Events

(16) Is the State of Delaware offering Open Enrollment Employee Education Sessions and Health Fairs again this year?

Yes, details on the dates, times and locations of these events can be found at de.gov/statewidebenefits (Select the “Open Enrollment” button).

Return to Table of Contents

(17) What are the Statewide Benefit Open Enrollment Employee Education Sessions and Health Fairs?

Employee Education Sessions provide employees an opportunity to engage, ask questions and learn about: What's changing in the health plan offerings on July 1, 2017; and how to engage in this Open Enrollment and take advantage of new and exciting consumerism tools Representatives from the various benefit vendors will be available 30 minutes before and after the event for employees to visit their information tables to ask questions and pick up materials/giveaways. Register online at de.gov/statewidebenefits (Select the "Open Enrollment" button) to attend one of the sessions.

The Statewide Benefit Health Fairs provide an opportunity for employees to explore the benefit vendor booths and learn more about their options. No registration is required.

You are welcome to attend the education sessions and health fairs if you are enrolled or are eligible to enroll in the State of Delaware Group Health Insurance Program (GHIP).

(18) Can my spouse and/or dependents attend the Statewide Benefit Open Enrollment Employee Education Sessions and Health Fairs?

Due to limited seating available, the employee education sessions are not offered to spouses and dependents. Spouses and dependents who are enrolled or eligible to enroll in the GHIP are welcome to attend the health fairs.

Covering a Spouse or Dependent(s)

(19) Who can an employee cover?

An eligible employee can cover a legal spouse and children under age 26. For more details about eligibility refer to the "Group Health Insurance Eligibility and Enrollment Rules" available at de.gov/statewidebenefits**.**

(20) What do I need to do if I choose to cover or continue to cover my spouse by electing "Employee & Spouse" or "Family" health coverage?

Contact your Human Resources Office within your organization for forms to enroll, make changes or cancel current health. You **MUST** complete a new Spousal Coordination of Benefits (SCOB) form each year during Open Enrollment and anytime your spouse's employment or insurance status changes.

Complete the Electronic SCOB Form online at www.ben.omb.delaware.gov/documents/cob by May 26, 2017.

(21) What will happen if I don't submit the Spousal Coordination of Benefits form?

Failure to complete a new Spousal Coordination of Benefits (COB) form by May 26, 2017 will result in a reduction of spousal benefits.

Return to Table of Contents

(22) What do I need to provide if I am covering a spouse or other dependent for the FIRST TIME?

Proof of eligibility must be provided for anyone covering a spouse or dependent for the **FIRST TIME**.

- Proof of eligibility for a spouse is a copy of the Marriage Certificate/Civil Union Certificate.
- Proof of eligibility for a dependent is a Birth Certificate or other legal document.*
- Social Security Card must be provided in order to confirm a spouse or dependent's Social Security Number
- Complete a Child Dependent Coordination Benefits form if your dependent child has other health coverage. The appropriate Highmark Delaware and Aetna forms and instructions are available at www.ben.omb.delaware.gov/medical.
- Complete a Certification of Tax Dependent Status form if enrolling a spouse due to civil union or other dependents due to civil union.

**This information is not forwarded to the carriers. Your Human Resources/Benefits Office will maintain this documentation*.

(23) What do I need to do if I choose to cover my children due to civil union for the FIRST TIME?

Contact your Human Resources Office within your organization for forms to enroll, make changes or cancel current health coverage. Additional information about benefit coverage for spouses due to civil union can be found at www.ben.omb.delaware.gov/cusgm.

(24) What if my spouse or dependent child(ren) have other coverage?

The Spousal Coordination of Benefits (SCOB) form **MUST** be completed if you are enrolling or continuing to cover your spouse in one of the State of Delaware Group Health Insurance health plans through "Employee & Spouse" or "Family" coverage. Dependent Coordination of Benefits forms must be completed for each enrolled dependent regardless of age, upon enrollment in other health coverage, any time other health coverage changes, or upon request by the Statewide Benefits Office, Highmark Delaware or Aetna. Your health insurance carrier will then coordinate benefits if there is other insurance coverage. To ensure the highest level of coverage for your dependents, you must notify your carrier if your dependent has other coverage. Additional information regarding the coordination of benefits is available online at www.ben.omb.delaware.gov/documents/cob.

(25) What happens when my dependent reaches the age of 26?

You are responsible for notifying your Human Resources/Benefits Office within your organization within **30 days** of the time when your dependent is no longer eligible for coverage. Dependent coverage is available until the end of the month in which your eligible dependent turns 26. As long as you notify your Human Resources/Benefits Office that your dependent is no longer eligible for coverage in the time frame listed above your dependent will be eligible to elect COBRA continuation coverage.

Return to Table of Contents

After I Enroll

(26) When will the new coverage take effect?
The new coverage and rates, or the termination of existing coverage will take effect on July 1, 2017.

(27) When will the deductions begin for these new plans or the new rates?
Contact your Human Resources/Benefits Office for information regarding benefit deductions.

(28) Will I get Member ID cards?

Health*:

- *Aetna*

  All members (new and current) in the HMO Plan and CDH Gold Plan will receive new ID cards. Aetna is partnering with Carelink CareNow for health and disease management for HMO members. Carelink CareNow contact information will be listed on the back of Aetna HMO ID cards.

- *Highmark Delaware*

  All members (new and current) in the First State Basic PPO Plan and Comprehensive PPO Plan will receive new ID cards.

Prescription*:

- *Express Scripts*

  Members who move to new health plans will receive new ID cards. ID cards do not auto generate for coverage tier changes.

**Please note that Health and Prescription ID cards will not be generated by vendors until the June 2nd interface files have been processed by vendors. ID Cards will be mailed mid to late June 2017.*

Dental:**

- *Delta Dental*

  Only new members will receive ID cards. ID cards do not auto generate for coverage tier changes.

- *Dominion National*

  Only new members will receive ID cards. ID cards do not auto generate for coverage tier changes.

***Please note that Dental ID cards are generated by vendors after each weekly file processes.*

Return to Table of Contents

Supplemental:

- *Aflac****
  Member ID cards are **not** issued for the supplemental benefits offered by Aflac.
  ****ONLY** University of Delaware employees are eligible to participate in supplemental benefits.*